ACRIN NLST 6654
Emergency Room Visits

F1/F2 Interval:  \_\_\_ -  \_\_\_ - 20 \_\_\_ \_ to  \_\_\_ -  \_\_\_ - 20 \_\_\_ \_ (mm-dd-20yy)

Facility Code:  _________________  ER Admission Date:  \_\_\_ -  \_\_\_ - 20 \_\_\_ \_ (mm-dd-20yy)

<table>
<thead>
<tr>
<th>ICD-9-CM Reason for ER Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Pre-existing (Comorbid) Conditions</td>
</tr>
<tr>
<td>ICD-9-CM Discharge DX and Complication</td>
</tr>
<tr>
<td>CPT Procedure Codes</td>
</tr>
<tr>
<td>CPT Procedure Codes</td>
</tr>
</tbody>
</table>

☐ More Codes
☐ More Visits
☐ No More Visits

☐ This form was created in error and should be deleted and all information should be ignored

✔️ = marked, ☐ = not marked

**Reason for form deletion:** (choose only one)

- ☐ 01 Query response
- ☐ 02 Data entry error correction
- ☐ 03 Audit QC Finding correction
- ☐ 04 Site revision

_________ - ________ - ________  - 20 ________

Abstractor ID  Abstractor Signature  Date Form Completed (mm-dd-20yy)

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